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ABSTRACT

Health professionals tend to view dying patients with two intertwined attitudes. On one hand the patient possesses an irreversible pathological condition and the doctor is obliged to help that patient embrace death with as much dignity as possible. On the other hand, the patient's imminent death is daily testimony to the limits of the doctor's competence. To avoid negative criticism from both patient and peers, the doctor often engages in avoidance behavior by stereotyping patients as to how well or how poorly they react to knowledge of death. If a patient establishes a trust relationship with a nurse, the nurse is more likely to disclose details of the diagnosis. Many nurses, however, engage in avoidance behavior similar to that of the doctors. A successful course in effective communication between patient and professional would (1) reduce the defensiveness a professional may feel toward peer and patient evaluation, (2) acquaint the professional with death by exposing him or her to a dying patient, (3) enable the professional to listen effectively to the ways the patient is handling death, and (4) enable the professional to structure appropriate response to the above. These goals might best be achieved in a hospice setting by a counselor who can alert the professional to signals patients give indicating the extent to which they have structured their dying experience. (HTH)

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TEACHING DEATH MANAGEMENT SKILLS: Health Professionals Confront Patient Avoidance Behavior

Speech Communication Association of Ohio
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The health professional tends to view the dying patient with a variety of attitudes. These attitudes, of course, arise from the meanings that the health professional attributes to the artifact of death. Two of these meanings seem painfully and inextricably intertwined. On one level, the physician or nurse may perceive the dying patient as a biological entity: he possesses an irreversible pathological condition; his present state does not respond to normal protocol medications; he has no other choice but to embrace his death with as much dignity and as little agony as possible; and he is to be the recipient of as much empathic confirmation from the medical staff as possible given the organizational constraints of the modern healing institution (Coe).

On another level of meaning, however, the health professional views the dying patient as professional artifact: the dying state of the patient is mute evidence of the physician's medical competence; the dying patient seems to indict the physician -- if he knew medicine he would not have allowed the patient to reach this terminal state and would not be required to accept such a singular destiny; when the patient dies, the physician will be required to face a hearing of his case with his medical peers to determine if all reasonable medical options were exercised to prevent the death; and if his patient dies while in his care, the physician feels responsible for the advent of his death. In an era of medical science when myriad treatments, surgical options, and pharmaceutical regimens may be administered to a dying patient, the physician or nurse is not likely to view death as the inevitable termination of biological pathologies. With such a banquet of medical options open to the modern health professional, it would seem reasonable to assume that the competent physician would not cease to try every known medical technique to rescue his patient from a "needless" death.

Yet when a patient dies, the health professional seems to question himself with: "What could I have done to prevent this death?" Thus, for the physician and nurse, the dying patient is the recipient of pity, as well as the cause of medical self-reproach.

From the perspective of our research and counseling practice with nurses and physicians, it appears that this double level of perceived meaning places the health professional in a communicative dilemma which reduces his/her choice options when dealing with a dying patient. Watzlawick et al. with their description of the double bind offer an interesting explanation of this health communication dilemma. In the double bind, one partner is given the illusion that he has no choice alternatives for the choice scene before him. With the terminal patient, the physician places himself in the double bind by the following line of reasoning: "If I am a competent physician, I will be able to bring health to my patients; my patient is dying, thus I must not be a competent physician." This paper will examine communicative behaviors among physicians and nurses which appear to arise from the double bind and will propose a method for training health professionals which may enable them to transcend the dimensions of this double bind in their interactions with the dying patients in their care.

The physician frequently engages in avoidance behavior with his dying patient. This interactional reticence is the result of the expectations of role norms which the physician brings to the healing scene. The physician often assumes that he has sole responsibility for the welfare of his patient. Thus when a patient dies, the physician assumes that he will be required to give account for the appropriateness of his treatment both to his medical peers and to his

patient's family. Thus the physician simply engages in avoidance behavior when the patient's condition is terminal to avoid negative criticism and assessment from his patient (Freidson).

Beyond the chance of opening himself to the possibility of criticism, the physician may further avoid discourse with his dying patient because he must explain the probabilities and uncertainties associated with treatment. Since the terminal condition is often fraught with uncertain prognoses, possible causes, and potential treatments, the health professional is often reluctant to admit to his patient that he cannot guarantee success rates of treatments and predict accurately the time which the patient may have to live. The physician assumes that if he communicates these uncertainties to the patient, the patient will equate these uncertainties with professional incompetence (Roth). The root of this fear of uncertainty and negative assessment may be traced to the physician's medical training. In medical school, the model that is encouraged of the competent physician is one who can give immediate and precise answers to questions posed by the professors. Students who answer without dysfluency and without vague qualifiers are judged to have the highest potential for competent medical practice. Thus physicians are often reluctant to discuss topics with patients in which they would need to betray uncertainty since uncertainty is so often equated with incompetence.

Further, physicians may often avoid discourse in the terminal scene with certain "types" of patients (Scheff). The physician attempts to reduce the uncertainty of discourse with the terminal patient by stereotyping each patient before him and making a prediction about the probability of success in dealing with this "type" of patient: "This type always gets hysterical." "I can't stand

the society matron type." "I don't have any luck with the silent type. You never know what they're thinking." These generalizations are frequently the only criteria by which the physician decides whether or not to disclose detailed information to a dying patient and to discuss potential modes of treatment. It appears that these patterned stereotypes may not arise from instruction the physician has received in formal training. Indeed, many medical students appear to be insulated from the artifact of death in their medical training (Oken). Instead of learning to interact effectively with dying patients by a systematic evaluation of attitudes and norms of discourse, many physicians, in practice, appear to adopt a mode of counseling learned by experience and haphazard encounters with extremes of patient behavior, rather than normal ranges of discourse. Many physicians thus avoid the patient by creating a negative label for the dying person in the hospital setting.

Some physicians may confront the patient with a partial diagnosis of his condition and then disclose the full seriousness of the diagnosis to family members. The relatives of the dying patient then are left in the uncomfortable situation of being uncertain about what the patient knows and what he wishes to know about his condition. Thus, some physicians avoid the task of painful interaction entirely.

Even if physicians have not chosen to avoid their patients and have decided to counsel a dying patient, some physicians still engage in subtle forms of avoidance behavior in their verbal patterns. The patient is often told of his diagnosis in general instead of specific terms (Quint). Many physicians follow the practice of hinting to the patient about his condition and disclosing the condition slowly to the patient. The aim of this strategy is to avoid the perceived

trauma of sudden revelation of the nature of the illness to the patient (Hinton). The physician may assume that the patient is not strong enough to tolerate the full dimensions of his illness. This reluctance to disclose pertinent information appears to be based on the physician's own fear of death (Brauer).

Another strategy of discourse employed by some physicians is the use of euphemisms (tumor, growth, lesion, neoplasm, lump, ulcer, mass) when describing the diagnosis to the patient. The use of these euphemisms may present such a milieu of unfamiliar jargon to the patient that he may even deny that he was ever told of the physician's diagnosis (Aitken-Swan and Easson).

Beyond avoidance behavior or the use of strategic euphemisms, some physicians may delegate the task of diagnostic disclosure and explication of prognosis to the nurse. Some nurses like the physicians, employ various strategies of avoidance of the death topic. Nurses, it appears, may also stereotype patients, and feel more comfortable with one "type" than with others. Glasser and Strauss ("Social Loss") found that nurses were more willing to discuss the patient's diagnosis if the patient were perceived as lower in status to the nurse. Organizational variables appear to affect perceived status of nurses and in turn, the amount of information the nurse is willing to disclose to the patient. Many nurses on the surgical floors of a hospital appear to have a higher status than nurses elsewhere within the hospital structure. Coser found that many surgical nurses perceived themselves as "co-physicians" in status and frequently speculated on a patient's prognosis while arguing the merits of various forms of treatment with both patients and physicians. If a patient establishes a trust relationship with a nurse, the nurse is more likely to disclose the details of a diagnosis even if the physician has ordered that the patient be told nothing (Glasser and Strauss,

"Temporal Aspects"). Further, the patient often learns what the physician has diagnosed about his illness from the cues that the nursing staff transmits to the patient (Gerle). An increase in dosage, a change of medication, and the announcement of new testing procedures often alert the patient to the seriousness of a diagnosis. Many nurses, as well as physicians, engage in avoidance behavior and topic manipulation when confronting the dying patient.

The survey of the literature and field observations of interactions involving health professionals, enable the following generalizations to be drawn about how the dying patient influences the discourse of physicians and nurses. (1) The health professional does not know much about the artifact of death. (2) He/she appears to fear death even though the physician or nurse views the dimensions of death on a daily basis. (3) Even though the health professional has high familiarity with the death scene, he/she has relatively naive methods for conceptualizing the scene and creating communication strategies which would lower uncertainty in the patient interaction. (4) The health professional perceives peer evaluation as a threat to his/her professional competence when the patient is diagnosed as being in a terminal state. (5) Nurses appear to feel less threatened by the death scene than physicians and appear to be willing to disclose inportant information about a patient's prognosis when establishing a trust relationship with the patient. (6) The patient is perceived by both physicians and nurses as recipient of information. In this role, the patient, in the eyes of many health professionals, has the potential for irratic and irrational behavior when he receives the full dimensions of his illness. Thus the health professional often views the patient as fragile. (7) Health professionals seldom allow the patient to take the initiative in dictating the quality of the relationship established

in the health care setting between patient and professional.

What method would be employed to teach effective communication to physicians and nurses who must interact with the dying patient? The method would be dictated by the goals of such specialized pedagagy, which in turn, would be dictated by the attitudinal constructs named above, which appear to be operative when the physician or nurse interacts with the dying patient. Thus, the goals of this type of teaching situation would be: (1) To reduce the defensive climate which the health professional may feel in this scene from peer evaluation and from patient evaluation. To meet this goal the course would incorporate individual instruction during the first sessions of the course. (2) To acquaint the physician or nurse with the artifact of death. To meet this goal, the instructor would expose the health professional to the dying patient in a non-healing setting. (3) To enable the health professional to listen effectively to the ways in which the patient is structuring the death for himself. To meet this goal, the physician would be instructed in a technique of data gathering and analysis. (4) To enable the health professional to structure appropriate responses to the patient's perception of the death artifact. To meet this goal, the health professional would be given practice sessions in response effectiveness with actual case studies and in-service training.

In order to attain these goals, the following pedagogy is suggested. The instructor for the course must be a person who carries counseling credentials and who has engaged in extensive death counseling. The class will be gathered from individual physicians or nurses who have approached hospital chaplains, patient advocates, or counselors for help in dealing with the dying patients in their care. The course should be limited to those persons who have asked for help in

order to focus the course on those persons who perceive that they have a need to improve their communicative effectiveness. This course should not be offered to hospital personnel for in-service training periods where student involvement may be marginal. If individual professionals approach the counselor/instructor for help, the following series of teaching events may be offered.

First, the professional will engage in an exercise in which his/her professional role as healer will be disengaged from normal healing situations. The instructor will arrange for the physician or nurse to conduct a series of interviews with a dying patient in a hospice setting. The patients would be selected for this exercise on the basis of how much congruity they have achieved concerning their own condition. Only those patients who have achieved a high degree of reconciliation with their self-concept and with their state of health would be asked to participate in this instruction exercise. The health professional would be introduced to one such patient as an associate of the instructor. The patient would then be asked to acquaint the professional with the environment of the hospice and share some of his/her thoughts about the setting. The instructor would leave the patient and the professional alone during this interview. If the professional is asked about his occupation, he would be instructed to tell the patient that he is a physician or nurse who is studying the hospice experience.

During the first interview, the professional is to be alert for topic breadth and depth. After the interview, the professional would meet with the instructor where he would obtain help in charting topic frequency and depth. He would be instructed in verbatim technique. After the instructor's session, the professional would search the patient's records for linkages between social experiences and

topic saliency.

During the second interview, the professional would listen and note attitude weights from the topics mentioned. Again, at the conclusion of the interview, the patient's records would be searched for a linkage between topics of high attitude saliency and social experiences.

On the third interview, the professional would be alerted for ways in which the patient had conceived of his death situation. The professional would be seeking to learn if the patient has given himself over to resignation of the event, to an attitude of conquest, to an attitude of struggle, etc. Again, at the conclusion of this session, the records would be searched for evidence from the patient's experience which would give rise to these conceptualizations.

At the conclusion of the interviews, the professional, with the help of the instructor would write a description of the patient's attitude structure based on evidence gained during the interviews. The analysis would be an attitude "map" of salient topics through which a professional could begin to generate ethos with the patient.

During the next step of the training process, the professional would meet in seminar sessions with other health professionals who have met in similar interview sessions with patients in the hospice. In this seminar, the professionals would report the results of their finds from each of their research projects. The goal of this seminar would be to draw generalities concerning the artifact of death and to estimate probable strategies for gaining access to dying patients in the future.

During the seminar, the professionals would each select a partner with which they could continue the training exercise. Each dyad would identify a terminal

patient from their own practice. In this phase, one partner would then interview the dying patient in the hospital setting, while the other partner would station himself outside the door of the patient's room and would record the interaction with verbatim technique. The professionals, meeting in dyads, then would critique each interaction and write pre- and post-analysis formats as prescribed in Russell et al.

The professionals would then return to the seminar setting, report on their field studies, give the verbatims of the encounters, and ask for suggestions from the seminar on how the encounter could be conducted more effectively.

The goal of this seminar would be to provide a permanent, open forum for the exploration of the topic of death for professionals who had completed the basic individualized instruction in the hospice setting.

The dilemma of how the physician or nurse perceives the artifact of the dying patient and his or her own professional competence, can be partially transcended if the physician/nurse is able to learn more about the artifact by the interview technique, is able to build supportive peer evaluation relationships in the seminar setting, and is able to increase the effectiveness of his own interview competence with his own patients.

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